Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JEFFREY GITT DO PC
3815 E BELL ROAD #2400
PHOENIX AZ 85032

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2916-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The consult code was submitted on 5-3-2010. The denial was sent on 7-9-10. We then resubmitted on 8-2-10 with a corrected code."

Amount in Dispute: $225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC MDR date stamp on the requestor's DWC-60 packet is 4/29/11. The date of 4/23/2010 …is greater than one year."

Response Submitted by: Texas Mutual Insurance Company 6210 E Hwy 290 Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2010	Professional Service	$225.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 9, 2010, November 8, 2010 and November 11, 2010.

- CAC-B18 THIS PROCEDURE CODE AND MODIFIER WERE INVALID ON THE DATE OF SERVICE.
- B93 THIS CODE IS INVALID OR NOT COVERED OR HAS BEEN DELETED.
- CAC-193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-29 THE TIME LIMIT FOR FILING HAS EXPIRED.
- 724 NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 731 PER 133.20 PROVIDER SHALL NOT SUMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05.
- CAC-18 DUPLICATE CLAIM/SERVICE.
- 736 DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION.

Issue

1. Did the requestor waive their right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." Review of the documentation finds that the request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on April 29, 2011 and that the date of service in dispute is April 23, 2010. No documentation was found to support that the dispute was timely filed to the MDR section, nor did the Division find that the disputed services involved issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section, consequently waiving its right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor waived its right to medical fee dispute resolution in this case. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Signature	Medical Fee Dispute Resolution Officer	December 29, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.